

KANSAS MEDICAID

48220										Ustekinumab (Stelara ®)									Request Date											
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Beneficiary Medicaid ID Number BENEFICIARY INFORMATION														N	Beneficiary Date of Birth															
Beneficiary Full Name																														
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Prescriber's Full Name PRESCRIBER INFORMATION																														
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_	Prescription instructions(sig):																													
2. Prescribed by a Dermatologist? Yes () No ()																														
3. Prescribed by a Rheumatologist? Yes () No ()																														
4.	4. Does the patient have plaque psoriasis? Yes () No ()																													
5.	ls tl	1е р	atie	nt a	a ca	ndio	date	for	sys	stem	nic (or p	hot	othe	erap	y? `	Yes	(_) 1	lo (_)								
6.	Has	the	pa	tien	t ha	ıd a	ТВ	tes	t in t	the	pas	t 12	mc	onth	s? \	es/	(_) N	lo ()										
7.	7. Please indicate if consumer is currently taking any other biologic therapy:																													
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May 2012

Signature of Prescriber_

FAX TO:

KANSAS Medicaid Prior Authorizations Fax: (866) 246-8512 PA HELPDESK: (877) 475 - 7567

*Prescriber signature mandatory



